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IN THIS AREA				Immunii	Zacions	J111	Y			
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PICA  1. MEDICARE MEDICAID	CHAMPUS	CHAMPVA	GROUP F	ECA OTHE	ISURANCE C			HIVI	(FOR	PICA PROGRAM IN ITEM
(Medicare #) X (Medicaid #)	(Sponsor's SSN)	(VA File	#) HEALTH PLAN E	BLK LUNG (SSN) (ID)	900000000					
2. PATIENT'S NAME (Last Name, First Barkley, Charles	Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY 09 06 2002 M	SEX F	4. INSURED'S NAM	(Last N	lame, Fir	st Name	, Middle	e Initial)
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP		7. INSURED'S ADDR	RESS (N	o., Stree	t)		
22 Basketball Blvd.		STATE	Self Spouse Ch  8. PATIENT STATUS	ild Other	CITY					STATE
Raleich		NC:	Single Married	Other						John
1 .	PHONE (Include Are		Employed Full-Time	Part-Time	ZIP CODE		TE	LEPHON	IE (INC	LUDE AREA CODE
27600 ( 9. OTHER INSURED'S NAME (Last Name	919) 555–121 ne, First Name, Middl		10. IS PATIENT'S CONDITION	Student ON RELATED TO:	11. INSURED'S POL	CY GRO	DUP OR	FECA N	UMBER	3
a. OTHER INSURED'S POLICY OR GR	HIP NI IMBED		a. EMPLOYMENT? (CURREN	T OB BDEMOTIES	a INCURENCE CO	05.5.5	ru			
a. O. IENTINGGILED'S POLICE OF GR	Jo. Homoth			NO NO	a. INSURED'S DATE	D YY		м		SEX F
b. OTHER INSURED'S DATE OF BIRTH SEX			b. AUTO ACCIDENT?	b. EMPLOYER'S NAME OR SCHOOL NAME						
c. EMPLOYER'S NAME OR SCHOOL N			c. OTHER ACCIDENT?	c. INSURANCE PLAN	NAME	OR PRO	GRAM	NAME		
d. INSURANCE PLAN NAME OR PROG	DAM NAME		YES 10d. RESERVED FOR LOCAL	NO	<u> </u>					
U. INSULANCE I ENVIAME OF PROS	DAM NAME		TOO. NESERVED FOR LOCAL	. 035	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  YES NO # yes, return to and complete item 9 a				complete item 9 a-d.	
12. PATIENT'S OR AUTHORIZED PERS	ON'S SIGNATURE	I authorize the I	& SIGNING THIS FORM. elease of any medical or other in	nformation necessary	13. INSURED'S OR A		ZED PE	RSON'S	SIGNA	
to process this claim. I also request pa below.	lyment of government	benefits either	to myself or to the party who acc	epts assignment	services described	l below.		·		,,
SIGNED			DATE		SIGNED					
14. DATE OF CURRENT: ILLNESS INJURY (	(First symptom) OR Accident) OR NCV(IMP)	15. 11	PATIENT HAS HAD SAME OF	R SIMILAR ILLNESS. D   YY	16. DATES PATIENT	UNABLE YY	TO WO	RK IN C	URREI MM	T OCCUPATION DD YY
14. DATE OF CURRENT: ALLNESS INJURY (PREGNA) 17. NAME OF REFERRING PHYSICIAN	NCY(LMP)		F PATIENT HAS HAD SAME OF REFERRING		18. HOSPITALIZATIO	N DATE	SRELAT	ED TO	CURRE	NT SERVICES
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